Common Emotional Problems of Adolescence

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SUMMARY

Common emotional problems of adolescence are discussed under three headings: those specific to adolescence; common psychiatric problems of adolescence, and those complicating physical illness in adolescence. Adolescence is a phase of emotional sensitivity and self-centeredness. The whole family is affected and may require professional support. As the adolescent moves towards greater independence, some turbulence and acting out is normal. Some make an impulsive break from their family by running away, others gradually gain their independence and some remain overly dependent. The latter group often become dependent on and demanding of their physician.

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ADOLESCENCE is a trying period emotionally. The adolescent is faced with rapid physiological changes and a sudden upsurge of adult-like sexual drive, at a time when he lacks the experience of an adult to cope with it. At the same time he experiences a need to gain independence from parents and feels a need to move away from them. He is reluctant to turn to parents for help. Instead, as he attempts to deal with the increased stress on his own, he is faced with an inner turmoil which is reflected externally as heightened irritability and sensitivity. Parents invariably fail to accept it as a part of adolescence, interpreting his behavior as undue moodiness and rebellion.

As the adolescent attempts to become more independent he withdraws from some of the emotional ties he developed with his parents during childhood. This results in a temporary phase of narcissism or self-centeredness, during which peer relationships become increasingly important. Feelings of emptiness, loneliness, boredom and unreality follow if close peer relationships are not substituted for the previously close parental relationship. During this phase the adolescent feels alienated and peer acceptance is vitally important. Peer pressure can lead to acting-out behavior; he may experiment with sex and/or drugs, or become involved in more serious antisocial behavior.

Many become disenchanted. They reject society, especially the middle-class work ethic. They wish that society (their parents, their schools, their community, their country, and even the world) were different. The disenchantment is partially related to the fact that the adolescent has just developed the capacity to abstract, i.e., to think about thought itself.[1] He becomes capable of manipulating and thinking about mere possibilities. This newfound skill leads to an overintellectualization and an overidealization about possible changes in society, without the necessary experience to understand what difficulties might be encountered in striving for these idealized goals. When they consequently become unattainable, he becomes disenchanted and disillusioned with society.

Writers disagree on whether the transition from childhood to adulthood should be a turbulent process or a smooth and gradual one.[2-8] Anna Freud has expressed special concern for the 'good' children who experience a non-turbulent adolescence.[4] She is of the opinion that a period of adolescent turmoil and rebellion is inevitable, predictable and normal. Under normal circumstances some adolescent turmoil is usual. However, one must be open-minded on the degree of rebellion.

Emotional Sensitivity

The adolescent's emotional sensitivity is partially related to the hormonal, physical and body image changes of adolescence. In addition, he must become independent of parents and move towards heterosexuality. Many become anxious – every adolescent, however 'normal', may question his own sanity when he experiences this anxiety.

Adolescents are sensitive to comments about their personal appearance. Body image concerns cause them much anxiety. Comments on their size, weight, acne, dress, etc., must be carefully worded. Critical comments about the adolescent's family, friends, school, etc., even if he has just run them down, may be viewed as attacks on his personal being. The adolescent who has spent the six previous office visits complaining about his parents may be infuriated when the physician makes even the slightest critical comment about them. Because the adolescent is still struggling for his independence, he experiences your criti-

cism as a personal attack. His response will vary inversely with his own sense of security and self-worth. This in turn will depend to a large extent on the security of his relationship with his parents prior to the onslaught of adolescence. In other words, the quality of the adolescent's early parental relationship will affect the degree of turbulence he will experience in adolescence.

The most dependent adolescent is the one who is most adamant in his demands for independence.[9] His shrill and uncompromising insistence on total freedom and denial of any attachment to parents is often accompanied by behavior which is unconsciously calculated to pull parents into his affairs. The louder the adolescent screams that his parents treat him like a baby, the more intense are his dependency yearnings towards them. The same reasoning applies to the adolescent who is extremely angry with his parents for not being omnipotent. In his dependent way he wishes they were so that they could take care of him. The adolescent who has not yet resolved his struggle for independence is susceptible to becoming overly dependent on his physician and making unreasonable demands of him.

The physician must realize that the adolescent's attempt to 'make a buddy of him' is not really because the physician is such a great guy, but rather is an expression of excessive dependency needs. It is therefore essential that it be recognized as such and reasonable limits set on the doctor-patient relationship for the adolescent's own good.

Difficult Progress Towards Heterosexuality

Managing the adolescent's progress towards heterosexuality can be difficult. Adolescents are often embarrassed about the upsurge of sexual feelings and thus are often reluctant to talk about them. Adolescents, especially those who do not have peers close enough to confide in, often secretly fear that their feelings are abnormal. Feelings of closeness, especially to individuals of the same sex, may stir up concerns regarding their sexual identity. Reassurance that these feelings are normal alleviates much anxiety. Some of the less sophisticated adolescents may have some very puritanical ideas about masturbation. They may be greatly relieved to realize that the incidence of masturbation in adolescence is higher than one in one million, as had been assumed by one adolescent girl. She was greatly relieved to realize that over half of the girls her age masturbate. Most adolescents will talk freely about sexual fantasies and conflicts, especially if the physician is tactful and inspires confidence. It is important to back off if and when the adolescent is embarrassed by the questions and does not want to talk about them. In dealing with adolescents of the opposite sex to the physician, especially those who appear to have some unresolved Oedipal feelings, it is extremely important to allow them some physical and emotional distance. In some cases it may even be necessary to allow the adolescent to bring into the examining room a sister, a mother, or girlfriend. Strong incestuous feelings may arouse extreme feelings of anxiety when the adolescent is in a room alone with an older adult of the opposite sex.

If the adolescent has come for help involuntarily as a result of parental pressure, he may be extremely angry and resist talking to an adult about any topic. It is important to be sensitive to these feelings and to deal with them. The physician must not interpret the adolescent's silence as a personal affront – it must be recognized as a manifestation of the adolescent's sensitivity and displaced anger. The physician must be tactful, patient and reassuring. The adolescent's parents often need support to prevent them from despairing and then rejecting their sensitive adolescent.

Narcissism

As the adolescent attempts to withdraw from the close emotional ties to his parents, he does so with varying degrees of rebellion. This invariably leads to more problems for the parents than for the adolescent himself. As a result, it is more often the parents, the school or society who claim to be disturbed by the adolescent's behavior. This is not necessarily because the adolescent does not feel in conflict, but because of his narcissism it is difficult for him to admit it. He will therefore probably attempt to bluff his way and make the best of a bad thing. Indications that he too is unhappy are likely to be subtle and carefully hedged. He may appear at best to be asking for help against his parents rather than for himself. Even the adolescent who expresses a great deal of anger at having to see a doctor because his parents feel he has a problem will usually show that he too has some concerns by showing up for his appointment. To encourage him to do so, the physician should refrain from making an issue of the anger, but arrange for another appointment with the implied assumption that he will keep it. Most will.

In order to develop a trusting relationship with an adolescent it is extremely important to be honest and open with him. This is especially true with the younger adolescent, who may be more frightened by the implications of an evaluation than any other age group. He is old enough to realize some of the implications of the reasons for his parents' concern, but not old enough to be objective about it. It is therefore important to outline almost immediately after the adolescent enters the office what course the visit will take. A large proportion of adolescents are then able to relate some of the difficulties they are having and to do so without undue questioning or prodding. However, if the adolescent does not seem to be cooperating and the interview is beginning to resemble a verbal duel, it is important for the physician not to be too forceful in pursuing these topics. Physicians who work with adolescents cannot afford to get themselves seduced into verbal battles. It is often better for the physician to back off in a relaxed manner and admit defeat with a humorous comment, letting the adolescent know that he won that round. The adolescent's narcissistic insecurity allows him to recognize intuitively that he cannot work with an adult who is similarly afflicted.

Alienation

Many adolescents experience intense feelings of alienation as they withdraw from parents during their struggle for independence.[10] As the adolescent turns away from the dependent protective warmth of home and family, he usually moves towards closer peer relationships. If for some reason he is unable to develop meaningful close relationships outside of his family, he is apt to feel empty, lonely, depressed and alienated. His narcissism will not allow him to admit, even to himself, that these feelings are indeed there. It is therefore important for the physician to verbalize some of these feelings for the adolescent when he appears disturbed by them. The adolescent will be reassured to know that some adult understands him and does not reject him for feeling alienated. Many soon realize that

some of their feelings of alienation are their own distortions of reality. Their own ambivalent feelings about moving away from their parents often result in a need to project imagined feelings onto their parents. In some cases it is necessary for the physician to discuss these issues with the adolescent's parents and thus help them endure this phase. However, it is extremely important to keep in mind that for the adolescent, confidentiality is especially important. The physician must be ready to discuss openly with the adolescent anything which is also to be discussed with his parents.

At times the adolescent's concerns about confidentiality virtually become a paranoid preoccupation. Because the adolescent frequently feels alienated, not only from his parents but from adults in general, it may be difficult for him to verbalize openly his concerns about confidentiality. Instead he may suddenly appear anxious or even retract a statement after revealing something about himself. The alert physician will at this point guess that issues of confidentiality are troubling his patient. The issue must be discussed with all adolescents, yet complete confidentiality should not be promised. If this is done, and the adolescent later confides plans for serious antisocial behavior, suicide, or some other dangerous action which requires intervention, the physician will have to break his promise in order to enlist the aid of the parents or others.

Acting-out

Adolescents are often referred to their physician by parents, school authorities or legal authorities because of drug involvement or because of their sexual promiscuity. If this acting-out is only an aspect of the adolescent's attempt to emancipate himself, it will likely be just a passing phase, but it may be a symptom of more serious psychopathology. Signs of depression, or even early manifestations of a borderline or psychotic state must be looked for. In others the acting-out is a continuation of a childhood behavior disorder and an early phase of an antisocial personality disorder. These are often the most difficult to treat since their poor conscience formation allows them to become involved in destructive acting-out behavior with no sense of guilt or remorse.

For the depressed adolescent the acting-out may be a form of self-punishment. Whether the acting-out is a manifestation of a depressive illness or a phase of adolescent rebellion, it is important to attempt to help the adolescent see his behavior as self-destructive. For the psychotic adolescent, indiscriminate drug involvement or sexual promiscuity may be another manifestation of his impaired judgement. In-patient institutional treatment may be required for both the psychotic and antisocial youngster.

Running Away

Running away from home has long been viewed by adolescents as an 'instant cure'. It may be a short-lived impulsive act lasting several hours or it may signal a teenager's abrupt permanent emancipation from home. In recent years the latter has become a much more serious and common problem. Most large cities today have some area where large numbers of adolescents flock to escape from home life.

For some, as mentioned, it is an expression of their need to liberate themselves from their parents. For others, the running away symbolizes some severe family pathology. In the case of the 'chronic runner' the child has usually been subjected to parental rejection since, or even before, birth.

Most runaways come to the attention of various social agencies. However in some cases, the family physician or pediatrician is the first one contacted. Then the physician is invariably faced with parents who are reacting with a mixture of anger, guilt and shame. They are angry at their child's rejection of them. Some are guilty over their unconscious wish to rid themselves of the responsibility of raising a rebellious adolescent.

First the adolescent must be found. Parents should be encouraged to contact the police and local agencies catering to youth. In addition, parents could contact their child's friends, many of whom, though they have no intention of conspiracy, will help if they feel that it is in their friend's best interests. Most runaway teenagers want to be found and be convinced that their parents want them home. Even so, they will often resist in order to save face.

Next, the parents need specific advice on how to respond to their teenager once they find him or her. The physician should help parents adopt an unemotional attitude in understanding why a runaway was necessary. It is often valuable for the physician to offer a family appointment preferably within 24 hours, in an effort to clarify some of the family's conflicts. Parents and physicians should be open-minded and not assign blame to the adolescent; neither should they accept an unchallenged and oversimplified explanation from the child.

Depending on the response of the family and the adolescent, the physician may arrange further family sessions. He may refer the family to a family service agency, a psychiatric outpatient service or even an inpatient setting. In some instances it may be necessary to recommend placement of the child in a more suitable home.

Depression and Suicide

It is estimated that the actual adolescent suicide rate is four to six per 100,000 (about one-third that of the general population).[11] The adolescent is emotionally sensitive and prone to depression; however, he may avoid showing his true feelings. Instead his depression can manifest itself in delinquent behavior, drug abuse, running away or school and learning difficulties. In others it presents as hyperactivity, sexual promiscuity, pregnancy, boredom, withdrawal, or a variety of physical complaints.

The suicidal attempt in the depressed adolescent may represent a call for help. It may also be an adolescent's attempt to manipulate parents. The manipulative aspects of suicidal behavior should alert the physician to probable internal or family conflicts, which can be dealt with either by the physician himself or by referral of the family elsewhere.

The specific management of the depressed adolescent will depend on the severity and etiology of the depression. The previously well adjusted adolescent who is depressed because he is grieving the death of a close relative or friend will in all likelihood respond well within a few weeks, if given some understanding and support. However, the youngster who is still depressed over the loss of a loved one some years later is in need of more intensive psychotherapeutic help. The older adolescent who presents with symptoms of a severe depression without any apparent precipitating event may be presenting early symptoms of a manic-depressive illness or even schizophrenia. It is especially important to assess the suicidal risk in these cases.

The management of suicidal behavior, both threats and

attempts, depends on the evaluation of a complex set of factors. It is important to assess both the actual medical risk of the attempt and the adolescent's fantasies regarding the risk. The well planned attempted shooting or hanging has a much higher medical risk than does the impulsive manipulative overdose with six sleeping tablets. However, if the patient believed the six sleeping tablets would kill him, then the attempt must be taken seriously; he is certain to try again, but with more tablets. If the attempt is planned without provision for discovery, it is clearly more serious than if there are built-in rescue arrangements. A suicidal attempt in a psychotic youngster is *always* to be taken seriously especially when he hears voices telling him to destroy himself. The suicidal adolescent who has lost a loved parent through death is also a high risk. He may be driven to join the loved one.

Environmental stresses, especially family disintegration, should be assessed. The possibility of family compliance or even unconscious encouragement of suicidal behavior should be investigated. Also, the adolescent's wider social environment should be evaluated. Social isolation, poor school performance, parental loss, and disruption of important friendships such as romantic alliances increase the likelihood of repeated suicidal attempts. After weighing the multiple factors, the physician must decide on the advisability of referral to a psychiatrist and or of hospitalization. Parents of the suicidal youngster must be notified.

Unfortunately, even the most skilled therapist cannot always prevent the suicidal adolescent from killing himself. When this occurs the physician is then faced with the task of dealing not only with his own but also the family's feelings of grief, guilt and inadequacy.

Emotional Problems Complicating Physical Illness In Adolescence

Adolescents with long-term physical disorders are subjected to repeated emotionally stressful situations. Acute physical illness can also pose similar psychological threats which usually prove harmful due to their shorter duration.

Adolescents, like children, may blame themselves for their illness. This is especially so in the adolescent who has recognized or fantasized the hereditary nature of his disease. Then a 'why me?' attitude may result, in association with anger, sadness and or anxiety.

The chronically ill adolescent resents the frequent and often lengthy hospitalizations which mean separations from family, friends and school. In hospital he is expected to adjust to an unfamiliar and regimented environment. Not only adolescents but all patients receiving nursing care experience feelings of helplessness, embarrassment, and irritation. However, the adolescent is especially vulnerable and sensitive to being treated like a child, since he is in the midst of a struggle to prove he is no longer one.

Since adolescence is a period of increased body-image anxiety, injections, infusions, immobilization, surgery and other procedures arouse anxiety beyond the discomfort involved. Family members tend to change their attitude toward a sick child, frequently becoming overprotective and overindulgent. They may reject and criticize him for causing them much inconvenience. They may even neglect his care.

As in the case with most emotional states in adolescence, parents are affected by the illness. The physician must often deal with parents' anxiety as well as their denial and disbelief of the diagnosis. Parents may complain about being poorly informed by the physician and occasionally 'shop around' for further medical opinions in an effort to disprove the initial diagnosis. Once parents begin to accept the diagnosis and begin to mourn the 'loss' of their normal child they invariably become depressed and angry. At this point the physician should give parents the opportunity to express their sadness and resentment. For a period of time the physician should be prepared to accept some of the misdirected anger from the parents who may blame him for some of their child's problems. When the physician feels he cannot take the time to counsel parents through this phase, he should refer them to a good social worker who is trained to deal with these problems.

Conclusion

Much has been written and said about adolescence. It has been presented as a necessary period of turmoil, or even as a disease process. It is, however, a period of physical and emotional growth during which problems specific to adolescence must be resolved. When they are not resolved the adolescent is vulnerable to becoming anxious, depressed, and even psychotic. But fortunately, most accomplish the transition to adulthood all the same. ◀

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QUOTE

CHILDHOOD, n. The period of human life between the idiocy of infancy and the folly of youth — two removes from the sin of manhood and three from the remorse of age.

Ambrose Bierce (1892-1914?) in The Devil's Dictionary